APPENDIX B

REALIGNMENT HISTORY AND FUNDING

Realignment

In 1991, California faced a $14.3 billion-dollar budget deficit. Initially, responding to former Governor Pete Wilson's proposal to transfer authority over some mental health and health programs to counties, the Legislature considered a number of options to simultaneously reduce the state's budget shortfall and improve the workings of state-county programs.

In addition to dealing with the fiscal crisis, there were a number of concerns about mental health programs and services in California.

- *Lack of Stability in Mental Health Funding*. Prior to 1991, state funding for county mental health services was subject to annual legislative appropriation, which varied significantly from year to year, depending on the state's financial condition. At that time, 90% of the funding (Short-Doyle) for mental health came from the state, and the remaining 10% "match" was funded by the counties. Because the state share was so high, local mental health services were particularly vulnerable to reductions when the state was faced with financial shortfalls. In 1990-91 for example, state expenditures for community mental health programs declined by about $54 million, or 8.6% below the prior year's spending level. Mental health program experts and advocates were voicing concerns that the uncertainty created by the annual state appropriations process was harmful to the development of sound community programs. The instability in funding levels and uncertainty in the state budget process also discouraged county government officials from making the commitments needed to develop innovative programs. Before an innovative new program could be developed and implemented over several years, a county mental health department was at risk of having to scale back the commitment of funding and personnel for such efforts due to decreased state funding.

- *Constraints on Program Flexibility*. The lack of flexibility provided to counties to use the resources available to them in the most cost-effective and clinically effective manner was also a concern at the time realignment was considered. For example, prior to realignment each county was given a set allocation of beds for seriously mentally ill patients receiving a civil commitment to the state mental hospital system under the Lanterman-Petris-Short Act (LPS). Counties were also allocated state-funded nursing care beds known as Institutions for Mental Diseases (IMDs). A county mental health department did not have the option of using fewer LPS or IMD beds and instead using the money for much less-costly (and in some cases

potentially more clinically effective) community-based treatment programs. In effect, counties were required to "use or lose" their allocation of LPS or IMD beds even if more cost-effective options were available.

Counties were also concerned that much of the state funding for their mental health systems was in the form of categorical programs, by which specific state grants were restricted for use for programs assisting specific target groups of mentally ill individuals. This categorical funding approach limited the ability of county mental health systems to meet the specific mental health needs of their communities and to combine funding from various programs to coordinate services.

- *Lack of System Accountability*. Finally, the enactment of realignment was intended to provide more effective state supervision and oversight of local mental health programs. While the state had long collected fiscal and program activity data about community-based mental health programs, state policymakers had voiced concern that the state had little information about the effectiveness of the county programs it had funded.

The preparation of the *Master Plan* coincided with the realignment legislation. Furthermore, the *Master Plan* contained many elements, such as target populations and performance-based outcomes, which addressed the concerns discussed above.

The Legislature responded to all of these issues by enacting the Bronzan-McCorquodale Act, referred to as “Realignment”. Realignment was enacted by Chapter 89, of the 1991 Statutes. Realignment was a major change in the state and local relationship. The Realignment plan was intended to provide expanded discretion and flexibility to counties to expend State funding. The *Master Plan* provided the philosophical and contextual underpinnings for the legislation.

Realignment represented a new partnership between the State and the counties governing the provision of services. It shifted program responsibilities from the state to counties, adjusted cost-sharing ratios, and provided counties a dedicated revenue stream to pay for these changes in the areas of mental health, social and health services.

Addressing the fiscal and programmatic concerns described above, the Legislature also established a series of policy principals in implementing the realignment changes. These were as follows:

- *Dedicated Revenue Stream***.** Whereas a number of the realigned programs previously had relied on annual appropriations of the Legislature, realignment hinged on the dedication of a portion of the sales tax and Vehicle License Fees (VLF)--outside of the annual budget appropriation process--to selected programs. The intent of realignment was to provide greater funding stability for selected health, mental health, and social

services programs. At the same time, the Legislature maintained control of the allocation of these revenues to reflect legislative priorities.

- *Increased County Flexibility***.** The Legislature hoped to free counties from unnecessary state regulation of programs, provide counties the freedom to expand program eligibility or service levels at their discretion, and foster innovation at the local level.

- *Productive Fiscal Incentives*. In the years before realignment, it was clear in some cases that counties operated under fiscal incentives that did not encourage the most cost-effective approaches to providing services. By changing these incentives, the Legislature aimed to control costs and encourage counties to provide appropriate levels of service.

- *Shift Responsibility to Counties*. In many areas, realignment aimed to shift responsibility over program decisions from the state to counties.

- *Maintain State Oversight Through Performance Measurement***.** While shifting program responsibility to counties, the state wished to maintain a level of oversight over the administration of these programs. The Legislature expressed its desire to move towards oversight that relied more on outcome and performance-based measures and less on fiscal and procedural regulations.

- *Ability to Alter Historical Allocations***.** While the initial allocations to each jurisdiction were based on their level of funding just prior to realignment, the Legislature indicated its desire to equalize some future funding based on such factors as poverty incidence and changes in program caseloads.

County Mental Health Funding at Time of Realignment

Realignment transferred the amounts associated with pre-Realignment categorical programs, general community mental health funding, State Hospital civil commitment funding, and Institutions for Mental Diseases (IMD) funding. Table 1 shows the fiscal year 1990-91 funding sources used to calculate the resource base for use in fiscal year 1991-92.

Table 1
Fiscal Year 1990-91 Mental Health Funding Sources for Realignment

Funding Source	Amount
Community Mental Health Services	
Community Services	$399,115,884
Community Residential Treatment	8,635,746
Alternative to Jail	1,896,847
Targeted Priority Population	1,924,336
Residential Care	10,518,976
Homeless Allocation	11,052,211
Residential Rates County Share	1,829,000
Equity Funding	9,685,000
SB 1409 Restoration	4,000,000
Total Realigned Community MH Services	$448,658,000
State Hospital Services	
Gross Costs	$242,554,000
Less: County Share	-33,000,000
Total Realigned State Hospital Services	$209,554,000
IMD Beds	$87,727,000
Wards and Dependent Children (SB 370)	$3,700,000
Total Mental Health Realigned Funds	$749,639,000

The realigned funds were broken into the CMHDA regions as shown in Table 2.

Table 2
Fiscal Year 1990-91 Mental Health Funding Sources for Realignment
By CMHDA Region

CMHDA Region	Amount	Percent
Bay Area	$202,221,830	27.0%
Central	102,100,979	13.6%
Southern	179,628,590	24.0%
Superior	26,969,757	3.6%
Los Angeles	238,717,844	31.8%
Total	$749,639,000	100.0%

In addition to the realigned funding sources, there was approximately an additional $525 million in other funding sources in fiscal year 1990-91 that were used to provide mental health services either through county mental health programs or Fee-for-Service/Medi-Cal providers reimbursed through the State Department of Health Services. These funding sources are shown in Table 3.

Table 3
Fiscal Year 1990-91 Non-Realigned Funding Sources

Funding Source	Amount
Third Party Revenues	
Patient Fees	$9,721,312
Patient Insurance	8,470,437
Medicare	31,306,968
Total Third Party Revenues	$49,498,717
Short-Doyle/Medi-Cal (Federal Share)	$126,659,276
County Overmatch	$95,161,871
Grants	$28,705,409
Other	$87,821,777
Fee-for-Service/Medi-Cal (State and Federal Share)	
Inpatient Services	$99,620,917
Professional Services	38,135,110
Total FFS/MC	$137,756,027
Total Mental Health Non-Realigned Revenues	$525,603,077

Thus, total mental health revenues in fiscal year 1990-91 were almost $1.3 billion, with the realigned revenues accounting for almost 60 percent of the total mental health program.

Revenue Sources

In order to fund the program transfers and shifts in cost-sharing ratios, the Legislature enacted two tax increases in 1991, with the increased revenues deposited into a state Local Revenue Fund and dedicated to funding the realigned programs. Each county created three program accounts, one each for mental health, social services, and health. Through a series of accounts and sub accounts at the state level, counties receive deposits into their three accounts for spending on programs in the respective policy areas.

- *Sales Tax***.** In 1991, the statewide sales tax rate was increased by a half-cent. The half-cent sales tax generated $1.3 billion in 1991-92 and is expected to generate $2.4 billion in 2001-02.

- *Vehicle License Fee***.** The VLF, an annual fee on the ownership of registered vehicles in California, is based on the estimated current value of the vehicle. In 1991, the depreciation schedule upon which the value of vehicles is calculated was changed so that vehicles were assumed to hold more of their value over time. At the time of the tax increase, realignment was dedicated 24.33 percent of total VLF revenues--the expected revenue increase from the change in the depreciation schedule.

  In recent years, the Legislature has reduced the effective VLF tax rate. As of 2001, the effective rate is 67.5 percent lower than it was in 1998. The state's General Fund, through a continuous appropriation to local governments outside of the annual budget process, replaces the dollars that were previously paid by vehicle owners. In other words, realignment continues to receive the same amount of dollars from VLF sources as under prior law. The VLF allocations to realignment have grown from $680 million in 1991-92 to an expected $1.2 billion in 2001-02.

- *The VLF Collections*. In 1993, the authority to collect delinquent VLF revenues was transferred from the Department of Motor Vehicles to the Franchise Tax Board (FTB) in order to increase the effectiveness of delinquent collections. The first $14 million collected annually by the FTB is allocated to counties' mental health accounts as part of realignment. The State Department of Mental Health in consultation with the California Mental Health Directors Association develops the distribution schedule.

Realignment Impact

At the state level, realignment was designed to stabilize funding for the mental health system. Many factors have caused increases and decreases to mental health funding over the past decade. Just examining funding levels before and after realignment does not clearly reveal whether realignment has stabilized funding. However, the structural change in revenue sources that provided dedicated funding for mental health services and the elimination of competition with entitlement programs for SGFs has improved the stability of funding. Other direct benefits to the state included a permanently reduced rate of state expenditures, availability of additional General Fund dollars to fund other state programs such as education and the fact that realignment protects essential programs for a vulnerable population.

At the county level, realignment reorganized authority and control over resources in the mental health system, creating a single system of care at the county level and giving counties control over their revenues. Realignment provided counties with additional flexibility regarding the use of funds that support services for county patients. These include services provided through state hospitals, institutions for

mental diseases (IMDs) and community-based programs. Beginning in 1992-1993, counties were permitted to use funds previously budgeted for the purchase of state hospitals services, for any mental health purpose with DMH having the authority to limit state hospitals transfers to 10%. Similarly, resources for IMD beds, which were previously directly contracted for by the State, were transferred to the counties. They can now use these funds for other mental health services or contract for these beds as needed.

From a fiscal standpoint, realignment has generally provided counties with the following advantages:

- A stable and growing funding source for programs which has made a long-term investment in mental health infrastructure financially practical
- Greater fiscal flexibility, discretion and control
- The ability to streamline bureaucracy and reduce overhead costs
- The ability to use funds to reduce high-cost restrictive placements, and to place clients appropriately
- Financial incentives to counties to properly manage mental health resources, including the ability to "roll-over" funds from one year to the next, which enables long-term planning and multi-year funding of projects

At the same time, it is important to note that realignment funding was based upon the current funding going to each county at the time of implementation, and did not address the basic under-funding that characterized the system prior to 1991. Even if the subsequent data analysis in this report were to show that realignment funds have kept pace with population growth and inflation, many would still believe that the public mental health system is under funded and unable to provide access and appropriate services to all persons with serious, disabling mental illness who need them.

Current Realignment Funding

With the recession in California, it took three years for the funding sources to restore counties to the funding level where they were before Realignment. Growth in the funding source after the first year was distributed first to reimburse counties for increases in caseload-driven costs for social service programs and then proportionately to the non-caseload-driven programs. In 1993, Chapter 100, Statutes of 1993 significantly amended the allocation of the realignment growth funds. Because revenues were less than anticipated, a Base Restoration Sub-account was established to restore each county to the level of funding originally projected in 1991.

State funding continues to be provided through two dedicated revenue sources: 0.5 cent of the sales tax and 24.33% of vehicle license fees (VLF) are deposited into the local revenue fund (Chapter 322, Statues of 1998, reduced the VLF revenues by 25%. The Statute requires the Department of Motor Vehicles to transfer amount

from the General Fund to offset the VLF revenue reductions into the Local Revenue Fund).

The Local Revenue Fund contains a Sales Tax Account, Sales Tax Growth Account, Vehicle License Fee Account, Vehicle License Fee Growth Account, and several sub accounts. The revenues deposited into these accounts are distributed by the State Controllers' Office to all counties and four city programs[1] on a monthly basis according to various formulas found in the statute. Annually, Realignment revenues are distributed to counties until each county receives funds equal to the previous year's total. Funds received above that amount are placed into a growth account. The distribution of growth funds is complex. However, it is a fixed amount annually and the first claim on the Sales Tax Growth Account goes to caseload-driven social service programs. Any remaining growth from the Sales Tax Account and all Vehicle License Fee growth are then distributed according to a formula developed in statute. Approximately two-thirds of the funds are distributed as "General Growth", proportionately to counties' share of the previous year's distribution. Originally, the balance was distributed to "under equity"[2] counties, in addition to their General Growth. The equity subaccount had a capped total amount, which has now been reached, thus that account has become dormant. All growth will now be distributed as General Growth to all of the counties. Largely because of caseload growth in child welfare/foster care and minimum wage increases in IHSS, growth distributions to health and mental health have been reduced in recent years.

Funds allocated by the Controller are deposited into and expended from the Mental Health, Social Services, and Health Trust funds at the local level. Revenues deposited into these accounts are used to fund programs specified in realignment legislation.
Counties are permitted to transfer funds between the accounts to reflect local needs and priorities among realigned programs. There are specific requirements as to the percentages of funds that can be transferred (generally 10% annually) and counties must provide information about substantial changes in their allocations of money among the three trust funds and document that the change(s) were based on the most cost-effective use of available resources to maximize client outcomes.

Realignment provides the fiscal foundation for local public mental health programs in California. It provides the most flexibility to meet local needs within a statewide framework of services to individuals with serious mental illness or serious emotional disturbances. It represents the largest source of revenue for local mental

[1]Only two city programs receive mental health realignment funds
[2] "Equity" is defined by Realignment as a county's percentage share of the statewide Realignment resource base in comparison to a combination of that jurisdiction's percentage share of the statewide population and the statewide poverty population (calculated as the sum of the above two percentages, divided by two). Those whose payments are a lower percentage than the population/poverty percentage are said to be "under-equity", which can be measured in dollars.

health programs, but represents less than 50% of total mental health funding statewide.

Other Mental Health Program Funding Resources

Medi-Cal

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The second largest revenue source is Federal Medicaid dollars. Understanding the changes in California's Mental Health Medi-Cal program since Realignment and the interaction of Medi-Cal revenues with Realignment are critical to analyzing the current structure and status of public mental health services in California.

In 1966, California passed legislation to implement the Medicaid program by establishing the California Medical Assistance Program in the Office of Health Care Services. Since that time, the program has become known as the Medi-Cal program, and now includes many additional specialized programs. The Department of Health Services (DHS) is the single state agency that administers the program.
The Medi-Cal program originally consisted of physical health care benefits with mental health treatment making up only a small part of the program. Mental health services were limited to treatment provided by physicians (psychiatrists), psychologists,
hospitals, and nursing facilities, and were reimbursed through the Fee-For-Service Medi-Cal system (FFS/MC).

There was no federal funding of the Short-Doyle program until the early 1970's, when it was recognized that county mental health programs were treating many Medi-Cal recipients. Short-Doyle/Medi-Cal (SD/MC) started as a pilot project in 1971,
and counties were able to obtain federal matching funds to provide certain mental health services to Medi-Cal eligible individuals. The SD/MC program offered a broader
range of mental health services than those provided by the original Medi-Cal program.

A Medicaid State Plan Amendment implemented in July of 1993, added services available under the Rehabilitation Option to the SD/MC scope of benefits and broadened the range of personnel who could provide services and the locations at which services could be delivered. This change is significant in analyzing the financial status of mental health programs because is enabled counties to greatly increase their claiming of federal Medicaid funds.

The SD/MC program now includes acute inpatient care, adult residential treatment, crisis residential treatment, crisis stabilization, intensive day treatment, day rehabilitation, linkage and brokerage, mental health services, medication support, and
crisis intervention.

The two separate Medi-Cal mental health systems, FFS/MC (the original Medi-Cal mental health system) and SD/MC, continued as separate programs until Medi-Cal mental health consolidation began in January 1995. From 1995 through 1998, there was a major shift in county obligations within the Medi-Cal Program. In order to provide counties more flexibility in the use of state funding and to enable more integrated and coordinated care, the State developed a plan to consolidate the two Medi-Cal funding streams for mental health services and implement managed care, a cost containment strategy that would allow a prudent purchaser of services to obtain maximum benefit for its expenditures and would allow for increased access to specialty mental health services within the same level of funding. Since research demonstrated that a single integrated system of care is critical for successful treatment of persistent mental illness and emotional disturbance and that the needs of persons with mental illness are not always paid adequate attention to in an all inclusive health care managed care system, the decision was made to "carve out" specialty mental health services from the rest of Medi-Cal managed care. County mental health departments were given the "first right of refusal" in choosing to be the mental health plan (MHP) for the county. All but two counties in California chose to become the MHP for their beneficiaries although there are provisions to choose another entity to be the MHP if a county chose not to assume that role. Those two counties chose to partner with another county to be the MHP.

The Medi-Cal Specialty Mental Health Services Consolidation program began in January 1995 with county mental health departments taking on responsibility for authorization and payment of all Medi-Cal covered psychiatric inpatient hospital services for beneficiaries in the county. (Three counties field-tested slightly different models.) Previously, county mental health departments had managed psychiatric inpatient hospital services only at county hospitals or hospitals under contract to the county. All other psychiatric inpatient hospital services were managed by DHS through the regular Medi-Cal program. Between November 1997 and July 1998, these county mental health departments, now called mental health plans (MHPs), also assumed responsibility for inpatient hospital professional services and outpatient specialty mental health professional services in addition to their previous responsibility to provide rehabilitative mental health and targeted case management services. This program operates under a federal freedom of choice waiver originally approved in May 1995 and subsequently renewed through the fall of 2002.

Under this waiver program each MHP contracts with DMH to provide medically necessary specialty mental health services to the beneficiaries of the county and are governed by state regulations in Title 9, California Code of Regulations, Division 1, Chapter 11. Medi-Cal beneficiaries must receive Medi-Cal reimbursed specialty mental health services through the MHPs. A distinction is made between specialty mental health care (those services requiring the services of a specialist in mental health) and general mental health care needs (those needs which could be met by a general health care practitioner). General mental health care needs for Medi-Cal

beneficiaries remain under the purview of DHS either through their managed care plans or through the FFS/MC system.

MHPs receive a fixed annual allocation of SGFs based on what DHS would have incurred for psychiatric inpatient hospital services and psychiatrist and psychologist services absent consolidation. Under the Early Periodic Screening Diagnosis and Treatment benefit (EPSDT), MHPs receive uncapped SGFs for services provided to full scope Medi-Cal beneficiaries under 21 for outpatient specialty mental health services above a baseline expenditure level. These funds, together with realignment funds may be used as the state Medicaid match for claiming federal matching funds. More detail about Medi-Cal funding and its impact on realignment are presented in the Revenue Analysis section.

Other State General Funds

Specific initiatives provide additional categorical SGF to county mental health programs. These are detailed in Table 4, which shows Estimated County Mental Health Funding for FY 2000/2001.

Table 4

Estimated
County Mental Health Funding
FY 2000-01

Realignment (Sales Tax and Vehicle Licensing Fees)	$ 1,000,000,000
County Funds	150,000,000
State Funds	
Consolidation/Managed Care	180,000,000
EPSDT (Medi-Cal services for children)	150,000,000
Adult Systems of Care (AB 3777 and AB 34)	60,000,000
Special Education Pupils (AB 3632/Chapter 26.5)	100,000,000
Includes SB 90 claims	
Children's Systems of Care	40,000,000
CalWORKs	50,000,000
Federal Financial Participation (FFP)	
Federal Share of Medi-Cal	575,000,000
Federal Share of Healthy Families	5,000,000
Other Funds	
Grants	
SAMHSA (Federal)	40,000,000
PATH (Federal for Homeless Projects)	5,000,000
Other Grants	15,000,000
Patient Fees and Insurance	25,000,000
Medicare	40,000,000
TOTAL	$2,435,000,000

Virtually all of these funds are targeted toward certain populations and come with their own sets of requirements. Some have specific eligibility requirements to serve new clients (such as CalWORKs and Healthy Families) or to serve an existing target population with expanded services (such as Adult Systems of Care and Children's Systems of Care). In many cases, no growth is built into these programs, nor do they always cover all of the administrative costs involved. They also come with expectations of collaboration with other government programs and the costs associated with these collaborations. While the benefits of comprehensive systems of service clearly outweigh these "unfunded" costs, they all put more pressure on mental health base funding.

Medicare

Medicare funding has always been very limited in coverage for mental illness and has no focus on rehabilitation or provision of care for case management. Recent federal efforts at cost control have further reduced the public mental health system's capacity to use Medicare in non-hospital settings.

Grants, Patient Fees and Insurance

The remaining sources of funding make up less than 5% of mental health program funding. As with the SGF programs, grants come with specific requirements and are often time-limited or decrease in amount over time.